church plan, the applicable federal agency is the Department of the Treasury. For a group health plan that is subject to Part 7 of Subtitle B of Title I of ERISA, the applicable federal agency is the Department of Labor. For a group health plan that is a nonfederal governmental plan, the applicable federal agency is the Department of Health and Human Services. The notice must include—

(*1*) The name of the plan and the plan number (PN);

(*2*) The name, address, and telephone number of the plan administrator;

(*3*) For single-employer plans, the name, address, and telephone number of the plan sponsor (if different from the plan administrator) and the plan sponsor's employer identification number (EIN);

(*4*) The name and telephone number of the individual to contact for further information; and

(*5*) The signature of the plan administrator and the date of the signature.

(B) The notice must be provided at no charge to participants or their representative within 15 days after receipt of a written or oral request for such notification, but in no event before the notice has been sent to the applicable federal agency.

(i) *Sunset.* This section does not apply to benefits for services furnished on or after September 30, 2001.

[62 FR 66961, Dec. 22, 1997]

Subpart D—Preemption and Special Rules

§ 146.143 Preemption; State flexibility; construction.

(a) *Continued applicability of State law with respect to health insurance issuers.* Subject to paragraph (b) of this section and except as provided in paragraph (c) of this section, part A of title XXVII of the PHS Act is not to be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of part A of title XXVII of the PHS Act.

(b) *Continued preemption with respect to group health plans.* Nothing in part A of title XXVII of the PHS Act affects or modifies the provisions of section 514 of ERISA with respect to group health plans.

(c) *Special rules*—(1) *General.* Subject to paragraph (c)(2) of this section, the provisions of part A of title XXVII of the PHS Act relating to health insurance coverage offered by a health insurance issuer supersede any provision of State law which establishes, implements, or continues in effect a standard or requirement applicable to imposition of a preexisting condition exclusion specifically governed by section 2701 of the PHS Act, which differs from the standards or requirements specified in such section.

(2) *Exceptions.* Only in relation to health insurance coverage offered by a health insurance issuer, the provisions of this part do not supersede any provision of State law to the extent that such provision—

(i) Shortens the period of time from the ''6-month period'' described in section 2701(a)(1) of the PHS Act and §146.111(a)(1)(i) (for purposes of identifying a preexisting condition);

(ii) Shortens the period of time from the ''12 months'' and ''18 months'' described in section 2701(a)(2) of the PHS Act and §146.111(a)(1)(ii) (for purposes of applying a preexisting condition exclusion period);

(iii) Provides for a greater number of days than the ''63-day period'' described in sections 2701 (c)(2)(A) and (d)(4)(A) of the PHS Act and §§146.111(a)(1)(iii) and 146.113 (for purposes of applying the break in coverage rules);

(iv) Provides for a greater number of days than the ''30-day period'' described in sections 2701 (b)(2) and (d)(1) of the PHS Act and §146.111(b) (for purposes of the enrollment period and preexisting condition exclusion periods for certain newborns and children that are adopted or placed for adoption);

(v) Prohibits the imposition of any preexisting condition exclusion in cases not described in section 2701(d) of the PHS Act or expands the exceptions described in that section;

(vi) Requires special enrollment periods in addition to those required under section 2701(f) of the PHS Act; or

(vii) Reduces the maximum period permitted in an affiliation period under section 701(g)(1)(B).

(d) *Definitions*—(1) *State law.* For purposes of this section the term ''State law'' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia is treated as a State law rather than a law of the United States.

(2) *State.* For purposes of this section the term ''State'' includes a State, the Northern Mariana Islands, any political subdivisions of a State or such Islands, or any agency or instrumentality of either.

§ 146.145 Special rules relating to group health plans.

(a) *General exception for certain small group health plans.* The requirements of this part do not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year if, on the first day of the plan year, the plan has fewer than 2 participants who are current employees.

(b) *Excepted benefits*—(1) *General.* The requirements of subpart B of this part do not apply to any group health plan (or any group health insurance coverage offered in connection with a group health plan) in relation to its provision of the benefits described in paragraph (b)(2), (3), (4), or (5) of this section (or any combination of these benefits).

(2) *Benefits excepted in all circumstances.* The following benefits are excepted in all circumstances:

(i) Coverage only for accident (including accidental death and dismemberment).

(ii) Disability income insurance.

(iii) Liability insurance, including general liability insurance and automobile liability insurance.

(iv) Coverage issued as a supplement to liability insurance.

(v) Workers' compensation or similar insurance.

(vi) Automobile medical payment insurance.

(vii) Credit-only insurance (for example, mortgage insurance).

(viii) Coverage for on-site medical clinics.

(3) *Limited excepted benefits*—(1) *General.* Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the plan, as defined in paragraph (b)(3)(ii) of this section.

(ii) *Integral.* For purposes of paragraph (b)(3)(i) of this section, benefits are deemed to be an integral part of a plan unless a participant has the right to elect not to receive coverage for the benefits and, if the participant elects to receive coverage for the benefits, the participant pays an additional premium or contribution for that coverage.

(iii) *Limited scope.* Limited scope dental or vision benefits are dental or vision benefits that are sold under a separate policy or rider and that are limited in scope to a narrow range or type of benefits that are generally excluded from hospital/medical/surgical benefits packages.

(iv) *Long-term care.* Long-term care benefits are benefits that are either—

(A) Subject to State long-term care insurance laws;

(B) For qualified long-term care insurance services, as defined in section 7702B(c)(1) of the Internal Revenue Code, or provided under a qualified long-term care insurance contract, as defined in section 7702B(b) of the Internal Revenue Code; or

(C) based on cognitive impairment or a loss of functional capacity that is expected to be chronic.

(4) *Noncoordinated benefits*—(i) *Excepted benefits that are not coordinated.* Coverage for only a specified disease or illness (for example, cancer-only policies) or hospital indemnity or other fixed dollar indemnity insurance (for example, $100/day) is excepted only if it meets each of the conditions specified in paragraph (b)(4)(ii) of this section.

(ii) *Conditions.* Benefits are described in paragraph (b)(4)(i) of this section only if—